To the Editor:

My congratulations to you on the splendid 50th anniversary issue of the *Hawaii Medical Journal!* It is most interesting and so appropriate that it should be dedicated to Harry Arnold Jr MD.

As Edith Bennett, I was managing editor of the *Journal* from 1944 to 1956. When I retired, the Hawaii Medical Association awarded me a lifetime subscription to the *Journal.* I have read it with great interest all these years. [But] Now that Harry Arnold is gone and almost all of my medical friends have retired or died, I should like to release you from the obligation to send me the *Journal* every month. I surely do appreciate all the issues I have had.

I am well and happy, living in this retirement community in Alabama.

Sincerely,
Edith C Robinson

Mrs A W Robinson
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The Editor Replies:

We appreciate the kudos and remember you as Edith Bennett. Thank you very much for updating the history of the *Journal.* We wish you well in your retirement far from Hawaii and have included your current address in hopes that some of your old friends here will write to you.

J I Frederick Reppun MD

To the Editor:

The mortality rate from the first recognized subarachnoid hemorrhage (SAH) remains near 50%. Many (up to 70%) have had an earlier unrecognized bleed — "the warning leak".

There remains a need for increased awareness and thus early diagnosis of patients who have had a subarachnoid hemorrhage secondary to cerebral aneurysm leakage or rupture. Surgical therapy can be life-saving.

Bleeding from intracranial blood vessels into cerebrospinal fluid, causing a subarachnoid hemorrhage, has several major causes: hypertension, trauma, congenital vascular anomalies, and aneurysms. The etiology can only occasionally be diagnosed accurately by history alone, eg trauma.

The patient with a subarachnoid hemorrhage needs early diagnosis and appropriate treatment. If the bleeding is from an aneurysm, this may only be diagnosed (proven) by CT brain scanning and/or cerebral angiography. It may be suspect after lumbar puncture. Hypertensive patients may also have aneurysms that bleed.

The neurosurgical emphasis today is on very early confirmative diagnosis and early surgery for selected cerebral aneurysms.

As soon as the diagnosis of SAH is made or suspected, the patient should be admitted directly to or transferred to a neurosurgical intensive care unit for cerebral and cardiac monitoring, CT scanning and cerebral angiography, all to be performed optimally within a few hours after the hemorrhage. If surgery is felt to be appropriate, it may best be performed within the first 48 hours after hemorrhage.

The timing of surgery remains an individual clinical decision. The surgical goal is obliteration of the aneurysm by clipping or ligation, with preservation of all normal vessels. This can be curative. Many clinical factors will determine the appropriateness of early versus delayed surgical treatment, but currently the emphasis is on early.

Thus, the patient, regardless of age, with a sudden or rapidly progressive headache, with or without loss of consciousness, and with or without significant nuchal rigidity must be considered as having had a subarachnoid hemorrhage until complete prompt evaluation has been performed and no hemorrhage and/or aneurysm has been demonstrated.

I hope this "current concept" of a lethal but curable cerebrovascular disease (aneurysm) will be of value.

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The Editor Replies:

We appreciate very much your letter above and commend you exceedingly for the effort; we do all, indeed, need to be made more alert to this entity, rare though it is. Thank you very much for defining so clearly a policy we all need to follow.

J I Frederick Reppun MD
Editor